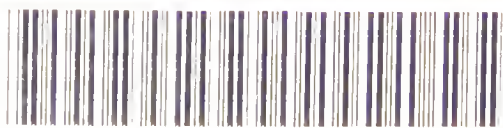


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## PREFACE.

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THE best thanks of the writer are due to Drs. Telford-Smith and Harry Campbell for the loan of blocks and to Drs. Radcliffe Crocker, Wyndham Cottle and Colcott Fox for so kindly correcting the cutaneous sections of this paper, thus bringing them up to the latest date.

Above all, he must record his obligation to Mr. Jonathan Hutchinson for placing at his disposal the priceless archives collected in his Clinical Museum.

Indeed, these brief notes may be said to have drawn their chief inspiration from the teaching of that accomplished and many-sided Surgeon and Biologist.

LONDON, 1898.



# ON THE

## STUDY OF THE HAND FOR INDICATIONS OF LOCAL AND GENERAL DISEASE.

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## INTRODUCTION.

ON those rare occasions when the aid of the European physician is sought for a female member of any Muhamedan family of distinction, the only part of the patient which the doctor is permitted to see is the hand, which is thrust for that purpose through a small opening in a curtain. Is it possible, we may ask, that a fairly respectable diagnosis might be based upon a sight of the hand alone?

Part of the purpose of this paper is to give a small instalment of the very large amount of general information that may be gleaned from a patient study of the hand itself.

The extent to which we may add to our knowledge concerning occupation, health, habit and character, by merely grasping the hand, would scarcely be suspected. How characteristic is the firm and friendly grip of a vigorous man, healthy alike in body and in mind! Should the hand be both horny and strong, we say "here is a man in whom muscular exertion enters largely into his method of earning his living, or at least of employing his leisure." If the palm be callous and the grasp be feeble, we think of xerodermia from arsenical poisoning, or of some other type of hyperkeratosis. An atrophic and dead hand might belong to leprosy or sklerodermia.

## TEMPERATURE, DRYNESS, MOISTURE.

The hand is often dry in cancer and in paralytic dementia. If the hand be dry and claw-like, the possibility of diabetes enters the mind; if hot, dry and emaciated, the hectic of advanced tuberculosis is suggested. When one hand is persistently hot and the other is cold, the case may be one of subclavian aneurysm, but it is much more likely to be gout or else lead-poisoning. If the palm be not only hot but also clammy, the causes may be excitement, recent exertion or hyperidrosis. A cold and dry hand may mean starvation, anæmia, feeble circulation, or one of the innumerable forms of vaso-motor ataxia. The hand is cold, harsh and swollen in myxœdema. If cold, clammy, and tremulous, then hysteria, dyspepsia, certain depressing emotions of the mind and the action of some nerve poisons, as alcohol, tea and tobacco, present themselves to us.

As regards the *appearance* of the hand, the first point that naturally attracts us is its colour, which it will be convenient to consider at the same time as its texture.

## COLOUR AND TEXTURE.

From the tint and texture of the hands, we may get many valuable hints as to occupation, habits, tendencies and mode of life.

Sometimes a profession is selected on account of the form of the fingers, while certain trades leave an imprint, more or less pronounced, upon the hands.<sup>1</sup> Thus artistic persons usually have slender and mobile fingers. Musical people have sensitive hands. We expect to see corns on the left finger tips of violinists, on all the fingers

of harp players ; goldbeaters have a thick right thumb, with large attached muscles ; copyists often show a corn on the little finger of the right hand, with a groove at the free end of the medius ; the pulp of the left index is pricked and blackened in seamstresses ; photographers have typical stains of pyrogallic acid ; turners and coppersmiths have flattened finger tips, the latter with green discoloration ; bricklayers, too, have flattening of the digital pulp, but this is on the left hand, and is chiefly seen on the thumb and index ; plasterers are marked on the left thumb and index with corns due to grasping the " hawk," which carries their cement. Coachmen also have corns on the right hand from using the whip and on the sides of the left fingers from friction of the reins.

By careful study of the hand, a fair hit can often be made as to inveterate habits. Thus, if with marked tremor of the hands, we notice that the forefinger and the thumb, especially if the left hand, be stained yellow, we may think of immoderate cigarette smoking ; whilst such widely differing causes as the use of arsenic as a cosmetic and certain forms of athleticism, such as tennis, will lead to thickening of the skin of the palm.

A white hand may mean good birth and idle habits, whilst an exceptionally white hand may show that, amongst other things, either the arteries are small in calibre or flaccid as to coat. Such a state of things may mean, too, that pigment is deposited in small quantities, or else that the arterial blood-supply is poor in quality or deficient in quantity. This would bring before our minds the possibilities of anæmia, of carcinoma, of toxics by tea, tobacco or sewer gas, or else by some inorganic poison as lead, arsenic or mercury. A smooth, thin, satin-like texture of the cutis, indicating atrophy, a condition usually associated with *asteatosis*, or lack of oil in the skin, betokens a result of neuritis, of nerve injury, or else of vaso-motor disturbance ; unless the patient be in advanced life, when a dry skin is normal.

The condition described by Langdon Down as "the woolly hand of imbeciles," in which the skin is loose,



harsh and thickened, is allied to or identical with the state of things in cretinism or infantile myxœdema.

A swollen hand, pitting on pressure, if bilateral and wax-like, would speak of advanced renal disease; on the other hand, if the œdema be unilateral, it would indicate axillary aneurysm, adenoma or traumatism. Swelling of the hands with bloated face might suggest alcoholism. A purplish tint, especially during warm weather, would hint at defective blood-aëration, starvation, scurvy or such a vaso-motor ataxia as we see accompanying various disorders which involve local asphyxia, as in Raynaud's disease. When combined with clubbing of the finger-ends, congenital mitral affection would be suggested, or we might think of Marie's disease (pulmonary hypertrophic osteo-arthropathy). On the other hand, it should be borne in mind that it is natural to some persons to have blue extremities. It sometimes causes no inconvenience, and it cannot then be viewed as a morbid condition.

Purple spots are found on the skin of the hands in a great variety of disorders. When the physician is summoned to a case of complete loss of consciousness, their presence may form a valuable element of diagnosis, in a condition which is always embarrassing enough. Should he hesitate between the coma of diabetes and that of uræmia, then the existence of yellow spots on the back of the hand would be in favour of diabetes, whilst purple maculæ<sup>2</sup> would point to uræmia.

Petechiæ on the dorsum of the hand might be due to the bite of a flea, to senility, scurvy, rickets, gonorrhœa, syphilis, small-pox, scarlatina, septicæmia, malignant endocarditis, pyæmia, jaundice, cancer, typhus, measles, albuminuria and Hodgkin's disease.

Many toxic agents have the power of producing petechiæ. Amongst the commonest are quinine, copaiba, mercury, belladonna, arnica, phosphorus and ergot, but above all the iodides. Some of the petechial eruptions attributed to syphilis are undoubtedly due to iodide of potassium. Purpura, followed by gangrene, has been recorded by Shephard as occurring after the administration by sodium salicylate;

such a condition might be mistaken for peliosis rheumatica (Schoenlein's disease).

Purpura accompanies many of the neuroses. It is seen with chorea and with rheumatism, but more especially with the myelopathies, such as locomotor ataxia and its allies. The sites of lightning pains are particularly prone to be visited by purpura.

All this means that the various forms of neuritis are prone to be followed by vaso-motor paresis, with consequent exudation of blood, which may be both altered in constitution as well as modified by the presence of morbid material.

If ecchymoses occur in a child, then we may think of the relapsing purpura of Henoch, formerly known as "febrile purpuric œdema," more especially if there be present the following group of characteristic symptoms:—Abdominal pain with tenderness on pressure, green vomiting and blood-stained stools, swollen and tender joints. A marked tendency to recurrence of symptoms at stated intervals of about eight days. Other juvenile forms are epidemic hæmoglobinuria, or Winckel's disease, in which the spleen is occasionally found enlarged. Some cases are complicated with acute fatty degeneration of the internal organs, the condition known as the disease of Buhl.

Many years ago, Graves of Dublin pointed out that purpura is very prone to be associated with the diarrhœa of children, now looked upon as nearly always bacillary.

If purpura occur in a girl, it is then probably either angio-neurotic œdema, or the morbus maculosus of Werlhof, known in this country as purpura hæmorrhagica. This disease sometimes proves fatal within twenty-four hours; it is then recognised as purpura fulminans. A very complete account of the different forms of purpura and allied eruptions may be found in Osler's "Medicine."

Ecchymoses easily form on the hands of the subjects of hæmophilia, a disease which differs from the other allied conditions by being nearly always hereditary.

When the petechiæ are associated with nettle-rash (purpura urticans)—and with these there are found to exist multiple arthritis, scanty and albuminous urine, and raised



temperatures—we may have to do with Schönlein's disease (peliosis rheumatica). Here sex and age will help us, for this disorder is practically confined to males between twenty and thirty years old. All the adult forms of the purpuric group are apt to be associated with arthritis.

If the nail be transparent, then a most convenient window into the circulation is afforded by it. It is valuable for viewing the state of the peripheral circulation. Various changes in the blood and in the tubes which convey it, such as arteritis, anæmia and supervenosity, may be estimated here. Again, capillary pulsation may be studied at this point.

Yellowish red papules or nodules, occasionally seen on the back of the hand, but more commonly on the elbow, may be xanthoma diabeticorum;<sup>4</sup> in any case the matter should be set at rest by an examination of the urine for sugar.

Larger and darker spots, round or oval in shape, known as "xanthoma, or xanthelasma rheumatica," but incorrectly, because they do not rise above the surface, are especially found on the hands, face, and neck. They are really a form of lentigo. When seen on the upper extremity, they correspond with the cutaneous distribution of the musculo-spiral nerve. The connection of these perverted pigment changes, with rheumatoid arthritis was recorded by the writer seventeen years ago,<sup>5</sup> four years before these changes were so fully re-described by Dr. Kent Spender, of Bath.

Brown spots, which do not disappear on pressure, are seen on the dorsum of the hand in the later stages of many of the diathetic diseases, notably in adult scurvy, in syphilis, osteo-arthritis, in tubercular phthisis, in carcinoma, and in xeroderma pigmentosa or Kaposi's disease, one common factor being the presence of the pyogenic process. Arsenical poisoning, Graves' disease, and morbus Addisonii, often have this symptom in common. When in Norway the writer observed brown pigment spots on the face and on the extremities of leprous subjects. However white the hands may have been, they usually grow red in the earlier

stages of rheumatic gout. At a later period the tendency is to grow brown. As the skin atrophies, the tone generally deepens, a brilliant blonde growing in time to be as dusky as an Asiatic.

### THE NAILS.

Paludal fever causes a typical change of tint in the nails. A peculiar slate-grey discoloration of the finger-nails appearing before the rigor, increasing during the cold stage, and attaining its maximum in the middle of the hot period, after which it slowly disappears, is said by Boisson, a French military surgeon, to be pathognomonic of an ague fit.

This is quite possible, because it is now known that the hot and cold stages of ague—the heat and cold, by the way, are subjective—correspond with the fission of the malarial protozoon. At this point a large proportion of the hæmatin has been destroyed by the protozoon, and converted into a melanic material, which is set free by the disintegration of the protozoon. The presence of this melanin in the blood, together with the diminution in the quantity of the hæmatin, would explain the grey look of the nails.

The nails are pale in hectic and in anasarca, grey in serious internal disease, yellow in jaundice, white in convalescence, chalky in some forms of paralysis, acutely livid in ague and chronically purple in cyanosis.

White spots on the nails are without doubt often due to local injury; but this is by no means the only cause. On two occasions Langdon Down<sup>6</sup> saw transverse white markings of the finger nail, occurring with ulcer of the cornea, in a professional man of studious habits. According to Geber, white spots indicate hypokeratosis.

That careful observer Murchison, noted that during the febrile state, in relapsing or famine fever, the nutrition of

the nails is impaired, white marks are developed upon them, co-incidentally with the attacks of pyrexia, but *not* with the apyretic interval.

Doubtless there are other pathological relations of white nail which will presently be observed and recorded.

The lunula owes its white colour to the fact that the matrix here contains a number of opaque elements which scatter light. These are the "transition," or so-called "keratogenous" cells. They stand midway between the prickle-cells and the nail-cells proper.

It has been asserted that brittle nails accompany diabetes mellitus; as a matter of fact, the subjects of glycosuria are prone to neuritis, and any form of peripheral neuritis, from gout to beri beri, may be followed by fragility of the nails. It is for this reason that the nail of advanced gout is so often either striated or laminated. This is not because the nail is gouty, but because gouty persons are so prone to multiple neuritis.

#### NAIL DEVELOPMENT.

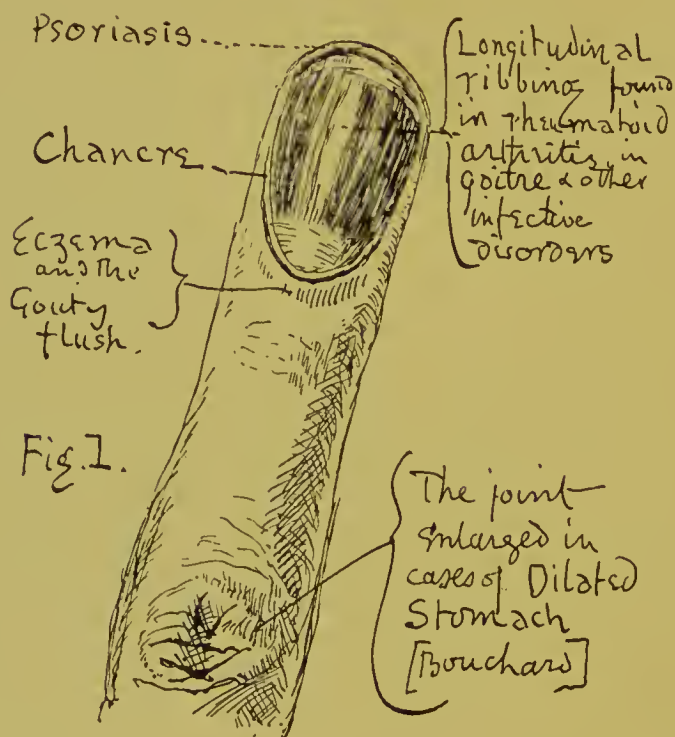
*Mode of Nail Growth.*—We will now step aside for a moment to consider very briefly the normal method of nail production. The changes in the upper surface of the nail must originate in the bottom of the nail-fold, for these are continuous. It is obvious too that the narrower the nail-fold, the more rapid is the growth of the nail and the less is its thickness.

The blood supply of the papillary layer of the substratum of the nail is divided into several areas each covered with rows of papillæ. The vascular supply is very peculiar, resembling in some respects an erectile tissue, such for example as that of the corpora cavernosa. The actual substratum consists of loose connective tissue, containing convoluted glands and some fat.

Milner Fothergill aptly compares a nail to a row of agglutinated hairs.

A glance at the dentated processes under the nail, alternating with the ridges of the nail bed, will show why the nails when atrophied, as after neuritis, must grow more and more ribbed, as they diminish in thickness.<sup>7</sup>

The finger nails are normally marked with longitudinal striæ in the anthropoids. In many infective disorders, as Graves' disease and rheumatoid arthritis, the nails are found to be ribbed and sometimes laminated.

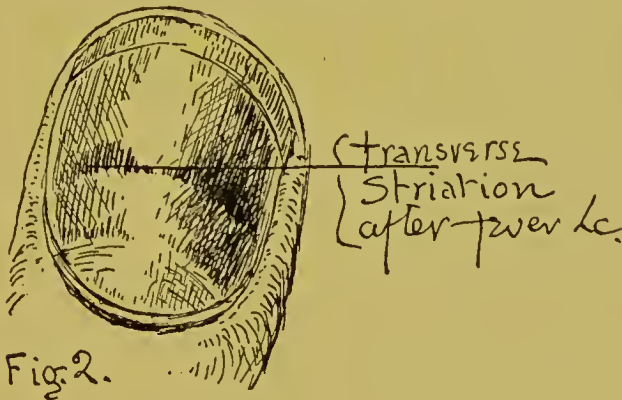


The children who can boast of a gouty ancestry appear to be especially prone to such vaso-motor disturbances as hæmophilia, and they are also addicted to nail biting. These two tendencies are not so wholly unconnected as they might seem at first blush to be. It is admitted that these children are neurotic in their tendencies; but I have observed



that their fingers are not irritable because they are bitten, but they are bitten because they are irritable.

A paint consisting of ten grains of ichthyol and one ounce of filmogen, applied to the nail-border after washing the hands, will often cure the habit by removing the irritation.



Transverse furrowing of the nail is a sign of temporary arrest of unguis development. It occurs in the acute fevers, especially in those accompanied by exfoliative dermatitis, such as scarlatina.

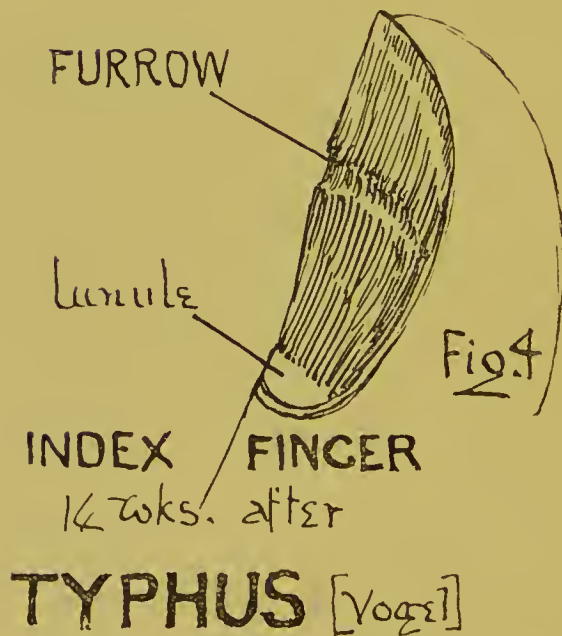
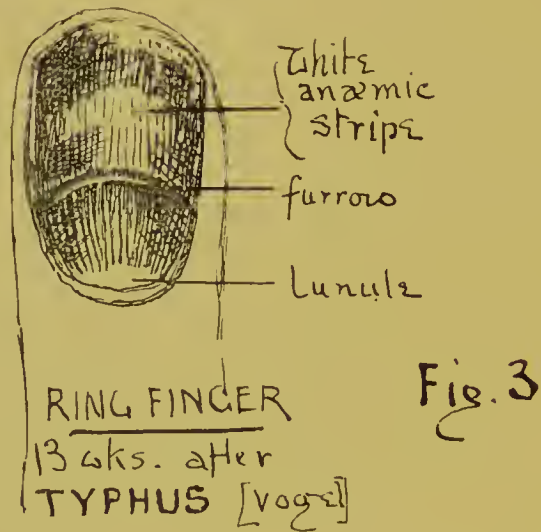
Some good observations as to the influence of typhus fever on the finger-nails, have been made by A. Vogel, see Bibliography. The two illustrations on p. 20 are drawn from his work.

Murchison has recorded at p. 517 of his work "On Continued Fevers," that the nails may present, in enteric fever, markings similar to those which follow an attack of typhus, and other acute diseases.

But an infinite variety of other causes will lead to transverse furrowing. Among them are surgical poisoning, peritonitis, sea-sickness, the opium habit, acute eye disease and influenza.

Increase of the lateral nail-curve is said to be a sign of syphilis; it is probably a result of atrophy of the finger pulp, the sides of the nail, losing their lateral support,

naturally fall in. It has been observed to occur, with brown discoloration, after hemiplegia [HUGHLINGS JACKSON]. Exaggeration of the longitudinal curve is quite a



distinct condition from clubbing of the extremities of the fingers; it will, however, be conveniently described with that peculiarity.

*Rate of Nail Growth.*—A considerable divergence of opinion exists as to the rate at which the finger nails grow. Beau gives as a rule that the nails of the hand grow one millimeter per week. At this rate the nails which average fifteen millimeters in length, would take 105 days to grow out. Dufour gives 121 to 138 days.

The fact is, the pace of growth varies very much, not only at different ages but in different individuals of the same age. Influenced by many external and internal conditions, the pace also varies in the same person from time to time. I have known a difference of seventy days between subjects of the same age and sex.

A few fresh observations will be submitted to the notice of the reader, as to the rate of growth of the finger nails in men at different ages :—

At 21 years, the nail was replaced in 126 days.

„ 31	„	„	„	159	„
„ 32	„	„	„	88	„
„ 55	„	„	„	110	„
„ 67	„	„	„	144	„

It is curious that in this group, the swiftest grower was a tubercular subject, who had a sharp attack of blood-spitting during the observation. Possibly we have here, as in hyperkeratosis, a suspension of inhibitory nerve influence. Compare with tubercular tachycardia.

Sea air is said to quicken the growth of the nails, profound grief has been known to destroy them.

A valuable point in diagnosis is afforded by the growth of the finger nail. In distinguishing between true paralysis of centric origin, and the various pseudo-paralyses of hysteria, which sometimes so closely simulate organic disease, it is well to remember that the growth of the nail is modified by most of the centric lesions, whilst its development is not affected by hysteria. It is asserted that intracranial hæmorrhages arrest the nail growth.

## PARASITES—ANIMAL AND VEGETABLE.

The presence of parasites may greatly modify the form of the nail. This can be understood when we remember that the eggs and the excrement of sarcoptes have been found by Bœck embedded in the actual nail substance. Under the influence of the scabietic occupation, the nail bed may itself become hypertrophied, whilst considerable bulging may take place along the centre of the nail longitudinally. The lower surface may be studded with irregular projections, alternating with hollows, either deeply excavated or conically depressed. The nails may become horny or claw-like, much thickened and having a yellowish white or brownish

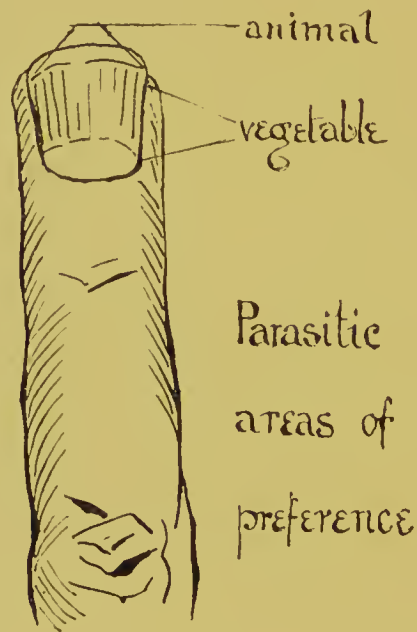


FIG. 5.

hue. On section they show an arrangement resembling asbestos, with whitish or yellow fibres. Bergh also found itch mites, eggs, egg shells, burrows, skin and excrement of parasites, in the substance of the finger-nails.

In warmer climates the sand flea—*pulex penetrans*—may cause violent pain and paronychia.

A nail which is pitted, frayed, and intersected by furrows,



discoloured, greyish or yellowish, opaque, and more or less lifted from its bed, would suggest the possible presence of vegetable parasites. These tend to attack the side of the nail, whilst animal parasites prefer the free border, the peculiar province of psoriasis.

The chief forms of onychomycoses are favus and tinea trichophytica.

The effects of vegetable parasitical invasion are, that after a considerable time the matrix becomes involved. Growth changes take place, the nail becoming claw-like and solid in some cases. In others the nail may come off in flakes, leaving a surface of faded dirty yellow colour, a most disfiguring condition.

The finger nails are great sinners in the way of disease-convection. They may carry the staphylococcus from the hairy scalp, affected with seborrhœa, to punctate acne of the face, thereby changing it to acne pustulosa. The tubercle bacillus can be thus conveyed from an itching nostril to a cutaneous gland or to the edge of the eyelid, setting up upus vulgaris. See an article by the writer in the *Lancet* of December 27, 1890. To quote the terse and vigorous words of John Chiene, of Edinburgh, a dirty finger nail may carry "death and damnation in the way of child-bed fever to the lying-in room."

Thickening of the nail, usually found near the free extremity, is in this country usually caused by psoriasis. More rarely it results from eczema, lichen ruber, leprosy and filarious invasion. Certain neuropathic affections as neuritis, chronic myelitis and traumatism of a nerve trunk have been followed by this condition, which rejoices in the unattractive name of "onychauxis"!

The finger nails are *damaged* by syphilis, usually the acquired form, *destroyed* by congenital pemphigus, the latter leaving, however, the pulp; whilst in leprosy, not only the nail, but more or less of the finger itself disappears bodily, perishing through neurotrophic changes. One or more finger tips may be lost through frost-bite, ainhum, the disorder known by the name of Morvan, *i.e.*, analgesic paresis of upper extremities—now thought to be a form

of syringo-myelia—Raynaud's disease and other kinds of gangrene, by accident, by the surgeon's knife, and by congenital amputation.

Strongly allied to Raynaud's disease is acroparæsthesia, a condition sometimes known by the somewhat cumbersome and ungraceful term "erythromelalgia." The chief symptoms are swelling and redness of the finger-tips, with either pain, tenderness—which may amount to exquisite sensitiveness—or else numbness or formication. It occurs in the course of various hysterical and neurasthemic conditions; not rare as a sequel to the neuritis of influenza, and sometimes seen in tabes.

Should a surgeon have to remove any nail, he should be careful not to prophesy that the nail will not grow again. It is quite a mistake to suppose that even if the matrix be entirely destroyed, a nail cannot be reproduced.

Tulpius<sup>8</sup> gives examples of accessory nails which have appeared on the first phalanx after the removal of the second and third. They have even appeared on the metacarpals.

#### ERUPTIONS, INVASIONS, &C.

We come next to a point of extreme interest: it is the geographical distribution of skin diseases on the surface of the hand, over areas more or less defined.

The rules which govern this distribution are not indeed absolute, but within certain limits they are extremely accurate.

*Psoriasis* attacks that portion of the skin which corresponds with the free edge of the nail. Some parasitic disorders affect, for obvious reasons, the same area.

*Eczema*, on the other hand, elects as its favourite commencing site, the thin and delicate skin which, fringing the

lunule, lies immediately above the nail-fold. It is then known as "pot-boys' disease."

These areas of election form a curious exception to the old clinical rule that eczema elects the aspect of flexion, whilst psoriasis prefers the aspect of extension.

Psoriasis of the palm, unless produced by arsenic or by traumatism, is often associated with specific infection.

It may be roughly said that the dorsal aspect of the hand is the domain of gout and that the palmar side is the area of secondary syphilis.

The primary manifestation of syphilis on the hand has no elective site. The chancre is indeed occasionally found on the finger because, with the possible exception of the tongue, that is, next to the external genitalia, the point most exposed to infection. On the finger, a crack in the nail-fold or a hang-nail often decide the site of invasion.

We may bear in mind that chancre of the finger presents an entirely different appearance from that with which we are familiar in its more ordinary situation. It begins as a bright red spot, grows quite rapidly, and in a fortnight after its first manifestation it may exceed one centimeter in diameter. It is quite easy to overlook its specific nature.

It may be dull or rosy, depending for its tint on the tendency to venous stasis of the person infected. The surface may be very angry-looking during the active stadium, and when the acute stage has subsided, there often remains a typical brown spot which, to the initiated, tells its own story.

A ruddy injected line, raised slightly above the surface and bordering the lunular fold, is very suggestive of gout. It is interesting that a similar fold of epithelium, at the labial aspect of the insertion of the teeth, known as "the gingival organ," is also an area of election for certain gouty manifestations, for example, pyorrhœa alveolaris or Rigg's disease.

*Panaris or Paronychia.*—The site of whitlow is the site of primary specific infection of the hand.

The washerwoman's disease has been attributed to poisoning by soda, but the exceedingly valuable provings

on his own person, made by Garré, detailed in the *Fortschritte der Medicin*, vol. iii., No. 6, 1885, have put it beyond cavil that this form of panaritium is an invasion of staphylococcus, supplied by the soiled linen of the laundry. Garré established a most important point, viz., that the *S. pyogenes aureus* requires no breach of surface to enter the system. Only a little rubbing, such as is supplied by the collar at the back of the neck, is needed and an inflamed follicle or even carbuncle may be produced. The particular kind of micro-organism needed, being supplied from that convenient culture bed—the hairy scalp. This accounts easily for the elective points of localised abscess. The suppurative processes, localised on the nape of the neck, are especially prone to be followed by cheloid which, however, nearly always disappears spontaneously.

The possibility of either tubercular or syphilitic origin in the case of obstinate whitlow would of course be borne in mind, nor should we forget that panaris is a symptom which occasionally complicates syringo-myelia. The presence of analgesia, and the loss of the thermic sense, the well known signs of Charcot, will help to identify this not very common disease.

It is of the greatest possible importance to distinguish between the various forms of whitlow. Some belong to the family of the tuberculides; these are etiologically connected with the verruca necrogenica, seen on the hands of dissecting-room porters, house surgeons, cooks and butchers. These must not be confounded with the acute or chronic syphilitic ulcer; nor with the whitlow of septic infection, so often seen in underfed children in a house with defective drainage.

*Papillomata—Warts.*—Warts may be either simple or pigmented—the latter appear to be prone to take on malignant action under certain forms of irritation. All kinds of warts are apparently auto-infective. From this fact and from the success of local salicylic treatment, it seems probable that, if not actually induced by bacillary action, they form an appropriate nidus for bacteria, which serve to perpetuate, if they do not produce them.



Each of the great diathetic diseases may be represented by this lowly form of vegetation.

*Lupus vulgaris*, when found on the fingers, is often warty. The "necrosing nodule" of the French dermatologists is supposed by some to be of tubercular origin. *Lupus erythematosus* has, of course, no connection with any bacillus. A near relation to *Lupus erythematosus* is *angiokeratoma*, first described by Wyndham Cottle. It consists of a series of warts, covering small dilated veins. Both these diseases are associated with vaso-motor ataxia, and both occur in the subjects of the chilblain diathesis.

*Palmar Hyperkeratosis*.—Occasionally we find the palm looking like the skin of a young alligator or an old laundress; this condition, which was formerly known as *xeroderma volare* or *palmare*, is now recognised as *hyperkeratosis* or *keratodermia*. One may regret to hear it called, by some authorities on the skin, by the appalling name "hypercornification!" At a later stage large corns form, whilst between them there are frequently found deep and painful fissures. This state of things is often the effect, and sometimes a very remote effect, of arsenical poisoning.

*Epithelioma*.—Mr. Jonathan Hutchinson has adduced evidence of such importance, that epithelial cancer may follow arsenical poisoning, that a most searching scrutiny should always be instituted as to how far any given case may have been under the influence of that drug. It is important to remember that arsenic is not always introduced into the body as a remedy. It may be absorbed either from a cosmetic, from an art-fabric or from the use of arsenical soap; from a wall-paper or from tinned vegetables.

A mild herpetic rash on the palm of the hand is not unknown after influenza, also as a sequel of severe dysidrosis, and occasionally as a result of liberal drugging. More especially is this the case with the iodides and the bromides; though the real elective areas of both the bromodermata and the iododermata are the tracts of skin supplied by the fifth cranials and the musculo-spiral nerves. It is needless to say that the interdigital fossæ are nearly always sacred to scabies.

But many interdigital eruptions closely simulate true scabies. The skin of the region is thin and delicate, and, perhaps, for this reason children are especially prone to vesicular rash between the fingers. Cheiro-pompholyx, as well as many trade diseases, affect the interdigital fossæ. Amongst these are such forms of eczema as grocers' itch and millers' disease. Arsenic may induce such an eruption in bronzers and in artificial flower makers; whilst certain plants, such as the *primula obconica* and the *ampelopsis*, have been known to attack the finger spaces of florists and of gardeners.

#### FORM.

*General Contour of the Hand.*—There is seldom a great deal of subcutaneous fat found in the hand. Hence its absorption is not followed by such a marked change as is seen in parts of the body freely supplied with adipose tissue. The alterations caused by age and by those forms of toxic neuritis which accompany gout, rheumatism, &c., are due in part to outgrowths, to perverted muscular action, also largely to a true atrophy of the skin, which is always affected in these diseases. Another cause of the change of form seen in the hands, is the slowly progressive shrinking of fibrous tissue which has been the site of lymph effusion, itself due to a great variety of causes, including traumatism. A good example of this is Dupuytren's finger.

Dupuytren's contraction, always found on the palmar aspect, sparing the thumb, is often hereditary. A tight band passes from the root of one finger towards the wrist, usually in the ulnar distribution. It is tempting to view this band as being formed by one of the flexor tendons; as a matter of fact, it is never tendinous, the fascia is the real seat of this curious disorder.

It is an adult male disease, seldom seen in women, possibly because they do not carry a cane; rare in the young, suggesting trauma as an exciting cause.

It is not to be confounded with congenital contraction of the little finger, common to both sexes.

The distinctive features may be tabulated thus :—

*Congenital* form is often :

- (1) Hereditary; it is
- (2) Stationary and nearly always
- (3) Symmetrical.

*Acquired* form is usually

- (1) Unilateral; if bilateral, then
- (2) Asymmetrical, and it is essentially
- (3) Progressive.

Many of the sufferers from gout, and most of the subjects of rheumatoid arthritis, are prone to temporary attacks of chondritis with fibrous degeneration, followed by bulging of the cartilage, known as “lipping,” due to muscular traction on the opposing articular surfaces.

I will not go into the question of what is the distinction between Heberden's nodes and Haygarth's nodosities, about which so many doughty pathological knights have broken a lance! It is now the fashion to say that the former are gouty, the latter rheumatoid. We may note though that Heberden, in his original treatise, definitely states that these manifestations observed by him did *not* occur in the subjects of gout. I will merely ask the reader to note the highly interesting point that Bouchard found so great a proportion of cases having enlarged proximal phalangeal joints in his examples of dilated stomach (see p. 18). This has been confirmed by the writer. It may be added that it is the terminal phalangeal articulations which are usually found affected after oral and pelvic suppuration.

It is of interest to remember that whilst gout shows a marked preference for the hallux, the corresponding pollex so frequently selected by cerebro-spinal disease, as a commencing site, often entirely escapes the attacks of rheumatism and its allies. A notable exception is Fortescue Fox's “thumb-base arthritis,” usually traumatic. Here the palm becomes cupped and the freedom of thumb-play is gravely impaired.

Exostoses usually commence as degenerative changes in the cartilage. Those due to gout are often central, attacking the middle of the phalangeal trochlea. They are frequently unilateral, that is to say, confined to one side of the body. They may be solitary. Rheumatoid changes, on the other hand, are usually multiple, and though rarely symmetrical, are most frequently bilateral. This asymmetry accentuates the grotesque and hideous deformities seen in advanced cases of osteo-arthritis.

Muscular distortions, due to paralysis of the intrinsic manual muscles, such as the *main en griffe* of Duchenne, and those due to paresis of the extensor muscles of the forearm, as the wrist-drop of house-painters, usually owe their origin to centric changes in the nervous system.

The general shape of the hand and the special form of the finger, often afford considerable aid to diagnosis.

In an article published in *Pediatrics*, on October 1, 1896, Dr. Telford-Smith, of Lancaster Asylum, draws attention to a peculiar formation of the hand occurring in so-called Mongol idiots. Idiots of the Mongol type get their name from their remarkable facial resemblance to the Mongolian branch of the human family, a resemblance pointed out by Dr. Langdon Down in 1866; see Bibliography. Numerically they form a group which Dr. Shuttleworth estimates at about 5 per cent. of mentally defective children. They appear to be particularly prone to tuberculosis.

The condition is invariably congenital, and is probably a kind of cretinism.

The peculiarity in the shape of the hand, to which Dr. Telford-Smith calls attention, exists in the little finger and consists in a marked outward bowing or curve of this finger.

This curve is fairly well shown in the accompanying reproduction from a photograph of casts of hands taken from two Mongol idiots.

The skiagraph on the opposite page was taken from one of these hands. From it we see that the second phalanx of the little finger is considerably shorter than normal, whilst there is much lateral displacement of the terminal phalanx.





FIG. 6.— Casts of Hands of Mongol Idiots, showing curve of little finger.





FIG. 7.—Stunted Hand of Congenital Cretinism.  
(TELFORD-SMITH.)







FIG. 8.--Skiagraph of Mongol Hand.

Amongst the most typical variations are the stunted hands of congenital cretinism, the spade-shape of myx-œdema, the sausage-shape of acromegaly, the carrot-like fingers of rheumatoid arthritis, and the clubbed fingers of mitral disease and of pulmonary suppuration, especially of Marie's pulmonary hypertrophic osteo-arthritis.

*Clubbed Fingers.*—Long ere the refinements of modern diagnosis had followed the introduction of instruments of precision by Laennec, Simpson, Recamier and others, clubbing of the finger ends had been observed. It was held to be an important sign of "consumption." But this condition is not confined to consumption. It occurs sometimes in the course of bronchiectasis. Patrick Manson has seen it as a sequel to the evacuation of hepatic abscess by way of the respiratory passages. It has been described as a result of congenital heart disease. It is seen after nerve injury, pneumonia and spinal caries. No single factor, shared alike by these widely differing conditions, has as yet been made out. The matter is probably largely mechanical. The finger tip is the point of least resistance; it is not supported like the toes by boots. Venous and lymphatic flow may be both obstructed, whilst vaso-motor paresis is often present.

Dr. Vivian Poore has recently republished his Bradshaw Lecture of 1881, entitled "Nervous Affections of the Hand." He has ably treated this subject in a most thoughtful paper, drawing attention to the fact that clubbing is absent in patients whose legs are swollen with tortuous veins, nor is it always present in bronchiectasis with emphysema, where there is considerable venous stasis; to this we may add that clubbing forms no part of the phenomena of Raynaud's disease.

Dr. Poore describes the case of a lady of 50, who sustained a severe injury of the brachial plexus on one side. It was afterwards found that the fingers on that side were covered with scurf and affected with chilblains. The nails grew dead and white and they were harsh in texture. Glazed spots appeared at the root of the finger nails, whilst well-marked clubbing set in on the side of the traumatism.



A very complete bibliography of the subject may be found at the end of a capital monograph by Massalongo of Padua. It is in vol. x., M., of the *Policlinico*, published at Rome in 1897, by the Societa Editrice Dante Alighieri.

It is curious that all the cases of Marie's disease that have been recorded up to the present time have occurred in men. I have recently seen a woman of 35, suffering from a second attack of spinal caries. She had Pott's disease at 14, and is now much disfigured by the so-called "angular curvature." There is, however, no trace of Marie's disease in the finger tips; perhaps this is because the respiratory organs are not yet invaded by tubercle.

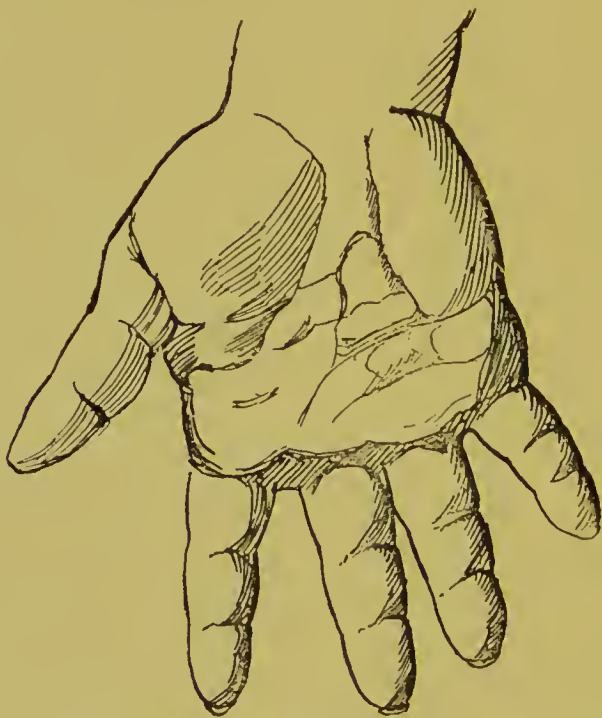


FIG. 9.—Acromegaly in the Adult. [Harry Campbell.]

Dr. Harry Campbell has pointed out a curious resemblance between the normal condition of the gorilla and the acquired bone and skin changes of the acromegalous subject. Many of the morbid signs in this disorder, first described by Marie in 1886, are examples apparently of reversion to a primitive arboreal type.

This is seen by comparing the acromegalous hand with the accompanying woodcut of a gorilla's upper hand taken from Hartmann.



FIG. 10.—Gorilla's Upper Hand. (*Taken from Hartmann.*)

The writer is indebted to the courtesy of Dr. Fisher, of King's Langley in Hertfordshire, for the opportunity of seeing a very typical case of Marie's disease, in the wards of the West Herts Infirmary.

The patient was a boy, aged 14, with a well marked angular curvature of the spine. There was a discharging sinus near the free extremity of each lower floating rib, forming the drainage from extensive spinal caries. The illness was as usual attributed to a blow; the child had fallen on the back at the age of 11 months. This may of course have been the immediate or exciting cause.





FIG. 11. —Clubbing of the finger-tips, in a boy of 14, with Mario's Disease.



silkeness of the skin by a harsh and parchment-like condition, at times alternating with a swampy and sodden state of things after exertion or emotion, is well seen on the legs of subjects of gout, rheumatism, myxœdema and goitre. Two or more of these morbid groups are often found blended together in what Mr. Jonathan Hutchinson has so happily termed "the partnership of diseases."

In some instances the skin thickens, whilst in others it becomes thin, tense and furfuraceous; it is sometimes covered with silvery scales, looking like a case of recent scarlatina, passing through the process of peeling.

These cases derive prompt and often persistent benefit from the inunction, after a hot bath, of thyroidin blended with some suitable lubricating material.

Dr. Kent Spender, of Bath, was the first in this country to draw attention, in 1885, to the fact that at some stage of the history of rheumatoid arthritis, the secretions of the skin are always disturbed.

*Edema*.—Persistent swelling of one hand, *without* discoloration, if acute, would suggest either peripheral neuritis or else traumatism higher in the limb. Obstructed vessels, venous or lymphatic, with or without glandular enlargement or other tumour, should be looked for in the axilla, whilst the possibility of aneurysm should be thought of.

Swelling, *with* discoloration, would, on the other hand, indicate either eczema, erysipelas, acute rheumatism or the action of some toxic agent, of animal or of vegetable origin.

Persistent swelling of both hands suggests albuminuria, from lead poisoning or some other cause. If renal disease be at an advanced stage, then the dorsum of the hand rises like a pincushion, the swelling being pale in colour and of most characteristic form.

Uræmic puffing is dusky. When purple maculæ appear on the cutaneous distribution of the musculo-spiral nerve, they form a portent of the gravest nature, death seldom being long delayed.

It may be remembered that the mere swinging of the arms during a long walk is quite enough to cause temporary œdema of the hands.



## SENSATION.

Such an infinite variety of causes lead to paræsthesia, or perverted sensation, of the fingers, that the needful limits of this paper quite preclude any attempt to give a complete account of them here. It will suffice to say that numbness in the superficial filaments of the median, in its digital distribution on the left side, is not necessarily a sign of heart disease. It may mean fifty things. Amongst the commonest are that this deadness of the left hand, more particularly when it occurs in the morning, may bear a relation to the posture assumed during the night, to the nature of the evening beverage, or to the habit that some have of uncovering the left arm when asleep. It may be hysterical or else mimetic. It has been known to disappear under the use of digitalis, apis, aconite, the tincture of St. Ignatius' bean, the salicylates and the bromides.

With regard to multiple or peripheral neuritis, it is the fashion to call everything "neuritis" now, although this is not justifiable unless there be present œdema, paræsthesia, either burning pain or else numbness, and loss of function, especially of coördination, followed by changes of skin temperature, tint, or texture, but more especially by certain trophic modifications. Without these typical phenomena a case should not be looked upon as one of "neuritis." The varied conditions known as "rheumatism" are different species of neuritis, usually toxic when polyarthritic; often traumatic—as pointed out by Fortescue Fox—when confined to a single joint.

All the infinite forms of neuritis may cause deadness of one or both hands, especially those induced by gout, rheumatism, alcoholism, catarrh, tea, tobacco and the modern anodynes and narcotics.

To these may be added a variety of conditions causing either general traumatism or else local pressure on the origin or course of the median nerve.

Widely different is the clinical significance of persistent numbness in the ulnar distribution. Comparatively few diseases are associated with loss of sensation in the little

finger. Prominent amongst them are leprosy and general paralysis of the insane.

It is scarcely needful to say that invaluable evidence of present or past lesion of cerebro-spinal origin may be derived from a study of the hand. This branch of the subject has, however, already received such careful and complete consideration at the hands of competent writers, that it is needless here to do more than refer the reader to certain valuable monographs, more especially to a paper by Francis Warner,<sup>11</sup> "On Postures of the Hand in Brain Disease," and to one by Long Fox "On the Hand as a Diagnostic Factor in Diseases of the Nervous System."

Very little has been said of Tremor manûs and its clinical significance. It is so large and important a subject that the writer deems it worthy of separate treatment.

### THE PULSE.

When an Oriental suffers the European physician to touch the wrist of the jealously secluded odalisque, the main idea is, of course, that the physician may feel the pulse. Yet of the pulse nothing has been said in this paper. Nor is this needful, for all doctors are supposed to understand the pulse. Yet I will venture to remind the reader that in cases in which there is a sluggish venous flow, as so often occurs in women with pelvi-portal congestion, a state of things by no means impossible in the idle atmosphere of a seraglio, the over-distended radial *venæ comites* might be easily mistaken for a high tension pulse, even when the artery is at the time nearly empty, as Leonard Hill<sup>12</sup> has shown by his valuable researches on the relation between venous pressure and pulse.

## NOTES AND REFERENCES.

- <sup>1</sup> See FORENSIC MEDICINE, by Husband. Edin.
- <sup>2</sup> First described by le Cronier Lancaster, of Swansea. See "Uræmic Eruptions," *Trans. Clin. Soc.*, 1892.
- <sup>3</sup> Purpura and Gangrene following use of Sodium salicylate. F. T. Shephard, New Syd. Soc., p. 369, 1897.
- <sup>4</sup> XANTHOMA DIABETICORUM, first described by Addison as "Vitiligoidia tuberosa." See his Works by the New Syd. Soc., also Guy's Hospital Museum.
- <sup>5</sup> LENTIGO RHEUMATICA, Blake on "Septic Intoxication," 1892, pp. 17, 18.
- <sup>6</sup> WHITE NAIL MARKINGS, by Langdon Down. See Jonathan Hutchinson's *Archives of Surgery*, February 1, 1870.
- <sup>7</sup> Nail ribbing, early noted by Milner Fothergill, as occurring in his own person after a gouty attack. "The Physiological Factor in Diagnosis." Baillière and Tindall, 2nd Ed., 1883.
- <sup>8</sup> *Observationes Medice.* NICHOLAS TULPIUS, 1716.
- <sup>9</sup> Dermatitis from *Primula abionica*. *Lancet*, SOUTHERN, Jan. 1891; SWAN, Ap., 1891.
- <sup>10</sup> Eczema caused by Virginian Creeper. *Lancet*, BURD, 1891, p. 17; PALM, 1891, p. 142.
- <sup>11</sup> *Spontaneous Postures of the Hand considered as Indications of the Condition of the Brain.* Brain, vol. vi. *The Hand and the Nervous System.* E. LONG FOX. *Wright's Medical Annual*, 1891. Ambrose Ranney on Diseases of the Brain and Nerves, New York. Buzzard on Syphilitic Nervous Affections. Gowers on Diseases of the Nervous System, vol. i. *Arch. für Psych.*, 1876. *Lancet*, vol. i., p. 543, 1882. *Brit. Med. Jour.*, vol. i., p. 589 and p. 654, 1889, and loc. cit., vol. ii., p. 1418, 1889, and loc. cit., vol. i., p. 735, 1890. *Lancet*, vol. ii., p. 119, 1890. Dreschfeld, *Brain*, vol. viii. Beevor, *Brain*, pp. 8-517. *Nouv. Iconographie de la Salpêtr.*, 1889-90.
- <sup>12</sup> *Effect of Venous Pressure on the Pulse.* LEONARD HILL. *Journal of Physiology*, vol. xxi., p. 147.

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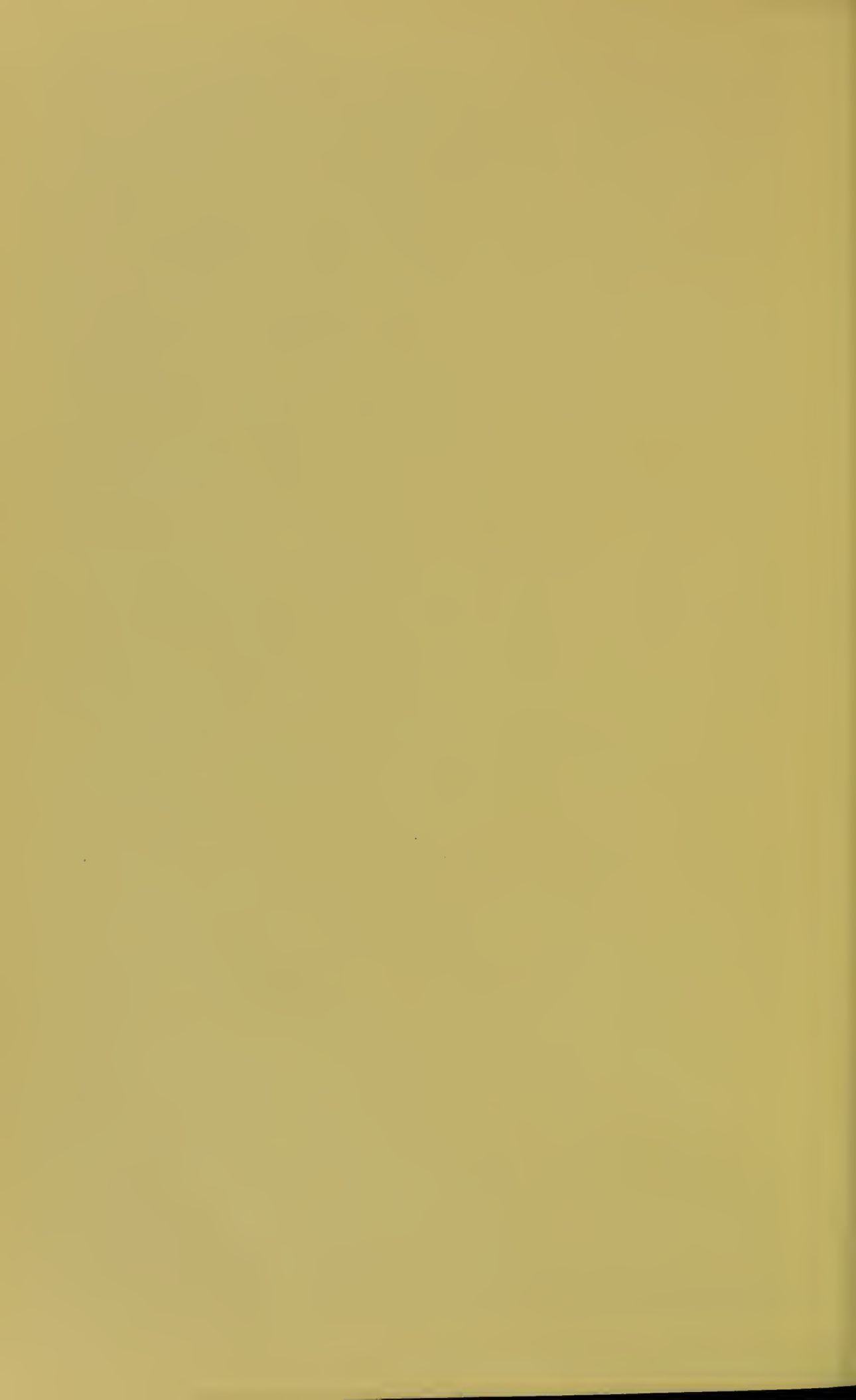




























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